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PATIENT INFORMATION

First:_____ MI: ___ Last: _____ Nickname: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Cell Carrier: _____

May we leave a confidential message at the above phone numbers? ☐Yes ☐No Email: _____

Please contact me with appointment reminders at: ☐E-Mail ☐ US Mail ☐Phone-Cell ☐Phone-Home ☐ Phone-Work

Employer: _____ Occupation: _____ Social Security #: _____

Emergency Contact Name: _____ Phone: _____ Other Phone: _____

Preferred Language:	Race:		Ethnicity:
☐English	☐American Indian or Alaska Native	☐ White	☐Not Hispanic or Latino
☐Spanish	☐Asian	☐ Other	☐Hispanic or Latino
☐Other _____	☐Black or African American	☐ Decline to Answer	☐Unknown
(Please indicate)	☐Native Hawaiian or Other Pacific Islander		☐Decline to Answer

PHYSICIAN INFORMATION

Your Primary Care Doctor Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Co: _____ Subscriber Name: _____ ☐ Male ☐Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance Co: _____ Subscriber Name: _____ ☐ Male ☐Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Vision Insurance Co: _____ Subscriber Name: _____ Male Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

AUTHORIZATION TO RELEASE INFORMATION / PAY BENEFITS DIRECTLY TO PHYSICIAN

I hereby authorize the release of any information requested by my insurance carrier concerning my present illness or injury.

I also assign to the group/physician whose name appears above all money to which I am entitled for medical and/or surgical expenses relative to the services reported. I permit a copy of this authorization to remain on file and be used in place of an original signature for claims filed.

I understand that I am financially responsible to said group/physician for charges not covered by this assignment.

I also understand that I will continue to be billed on all accounts not paid. If an insurance claim is pending, The Eye Clinic, PC will not be responsible for collecting and/or negotiating settlement on a disputed claim.

Patient/Responsible Signature: _____ Relationship: _____ Date: _____

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MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Date of birth:_____ Current occupation: _____

Primary care doctor:_____ Date of last visit and reason:_____

Date of last eye exam:_____ Location/doctor for last eye exam:_____

Do you drive? ☐ YES ☐ NO

If yes, do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you tried to wear contact lenses? ☐ YES ☐ NO

If yes, how long have you worn contact lenses? _____

Do you currently wear prescription glasses? ☐ YES ☐ NO

If yes, how long have you had the current prescription? _____

Do you **currently** have any problems in the following areas? If YES, please provide information.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching/burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
OTHER			

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy): _____

_____

Please turn page over ⇨

Do you **currently** have any problems in the following areas? If YES, please provide information.

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, weight loss, other)			
CARDIOVASCULAR (Heart, vessels, etc.)			
EAR, NOSE, MOUTH, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITOURINARY (Genital, kidney, bladder)			
MUSCULOSKELETAL (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypo/hyperthyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	**RELATIONSHIP TO PATIENT**	**DISEASE**	YES	NO	**RELATIONSHIP TO PATIENT**
Glaucoma				Diabetes			
Cataracts				Cancer			
Macular Degeneration				Heart Disease			
Eye Injury				Hypertension			
Retinal Disease				High Cholesterol			
Other Disease				Kidney Disease			
Blindness				Stroke			
Strabismus				Other (describe)			
Amblyopia				Other (describe)			

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1/day 2-3/day 4+/day

What is your smoking history/current use status? ☐ Current smoker: occasional ½ pack/day 1 pack/day 1+ pack/day

☐ Former smoker: how long ago did you quit smoking? _____

☐ Never smoked

Do you use recreational drugs? ☐ YES ☐ NO

List any **medications** you currently take (prescription and over-the-counter, including supplements):

_____

_____

Do you have **allergies** to any medications? ☐ NO ☐ YES (please list) _____

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FINANCIAL POLICY

Our primary desire is to help our patients have “eye-healthy” lives. In order to avoid any misunderstanding, we wish to state our following financial policy:

1. Co-payments are due at the time of your appointment.

2. If a referral is required by your insurance, you are responsible to obtain one from your primary care doctor prior to your appointment.

3. As a courtesy to you, we will submit an insurance claim for our services if you present your current health insurance card at the time of your appointment. This is not a guarantee that we have a contractual relationship with your insurance plan or that your specific insurance policy covers the services that were provided. If you do not hear from your insurance company within 30 days or you do not agree with their determination of payment, it is up to you to contact them to negotiate a solution.

4. You will receive a statement from us after your insurance company has processed your claim. This will include all charges that your insurance company has not paid. Your payment is due in 30 days, with late fees applied if your account becomes past due.

5. A 15% discount will be given to our uninsured patients for payment on the day of service (excluding eyewear and contacts).

6. You will be asked to pay for services in advance of care if your account is not kept current. You may also be discharged from our care and referred to a professional collection agency if your account becomes delinquent.

7. We are happy to offer a budget plan payment for medically necessary services. To arrange this, please contact our billing office at **503-292-2124**.

We accept VISA, MasterCard, Discover, debit cards, cash and checks. Our processing fee for returned checks is $30.00.

I have read and accept the financial policy above.

Name: _____

Signature: _____ **Date:** _____

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YOUR EYE EXAM: NOTICES AND FEES

Vision vs. Medical Exam

For insurance purposes, eye exams fall into two different categories: **Medical Exams** and **Routine/Vision Exams**. Medical insurance will not pay for routine eye care, and Vision insurance will not pay for medical eye care. The Eye Clinic is glad to assist you with either type of care, and we provide excellent Medical and Vision exams. Understanding the difference between a Medical Exam and a Routine/Vision Exam helps us bill your insurance correctly, and helps to prevent unexpected out of pocket expense to you.

- **Medical Exams** include evaluation, assessment and/or treatment for ocular medical conditions. Common medical eye conditions include cataracts, glaucoma, diabetic retinopathy, macular degeneration, dry eyes, eye infections and eye injuries. Medical exams are billed to your Medical insurance.
- **Routine/Vision Exams** include a general screening for eye disease and a refraction. A refraction is the measurement done to prescribe glasses and/or contact lenses. A vision exam does not include an in-depth evaluation or treatment of medical conditions. If your provider discovers a medical condition during your routine/vision exam, you may be scheduled for an additional appointment(s) to complete further evaluation and treatment.

I understand the difference between a Medical Exam and a Routine/Vision Exam _____*initial*

Refraction Fee

A refraction is the portion of an exam that helps determine your eyeglass prescription. It is an important component of an eye examination and necessary for determining the power of your glasses. Many medical plans, including Medicare, do not cover a refraction. If your plan does not cover a refraction, you will be billed a $60 refraction fee at the time of service.

I understand that refractions are not covered by Medical insurance _____*initial*

Contact Lenses

The FDA considers contact lenses Class II and Class III medical devices. Because of this, they are regulated by prescription laws, similar to prescription medications. Oregon law states that patients are entitled to a copy of their contact lens prescription each year after a fitting or refitting examination is performed. Fees for contact lens fitting, instruction and follow up range from $50-300, depending on the type and complexity of fitting services needed. This fee is in addition to a comprehensive eye examination.

I understand that additional fees may apply to contact lens evaluation and fitting _____*initial*

I have read this document and understand that my services will be billed to the appropriate insurance, based on the exam performed. I understand that additional fees apply for refraction and contact lens services, and I assume responsibility for any fees that are not covered by my insurance.

Name: _____

Signature: _____ **Date:** _____

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ACKNOWLEDGMENT AND CONSENT

I understand that The Eye Clinic PC will use and disclose health information about me.

I understand that my health information may include information created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that The Eye Clinic PC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how The Eye Clinic PC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of The Eye Clinic PC and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of The Eye Clinic PC's Notice of Privacy Practices in effect will be posted in each waiting room.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and understand that The Eye Clinic PC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____

Or By:_____ Date:_____
(legal representative of patient)